

SERFF Tracking Number:	AOIC-125823827	State:	Arkansas
Filing Company:	Owners Insurance Company	State Tracking Number:	EFT \$50
Company Tracking Number:	WCP-AR-04-09/19/2008-27016		
TOI:	16.0 Workers Compensation	Sub-TOI:	16.0004 Standard WC
Product Name:	Workers Compensation		
Project Name/Number:	WCP/27016 WCP		

Filing at a Glance

Company: Owners Insurance Company

Product Name: Workers Compensation

TOI: 16.0 Workers Compensation

Sub-TOI: 16.0004 Standard WC

Filing Type: Form

SERFF Tr Num: AOIC-125823827

SERFF Status: Closed

Co Tr Num: WCP-AR-04-09/19/2008-27016

Co Status: Pending

Authors: Claudia Stewart, Sarah Franklin, Jessica Turner

Date Submitted: 09/19/2008

State: Arkansas

State Tr Num: EFT \$50

State Status: Fees verified and received

Reviewer(s): Betty Montesi, Carol Stiffler

Disposition Date: 09/19/2008

Disposition Status: Approved

Effective Date (New): 09/19/2008

Effective Date (Renewal):

Effective Date Requested (New): On Approval

Effective Date Requested (Renewal): On Approval

State Filing Description:

General Information

Project Name: WCP

Project Number: 27016 WCP

Reference Organization:

Reference Title:

Filing Status Changed: 09/19/2008

State Status Changed: 09/19/2008

Corresponding Filing Tracking Number:

Filing Description:

FORM FILING: 27016 (07-08) - Owners Workers Compensation and Employers Liability Insurance Policy

Submitted for your approval is the above-referenced form. Forms are submitted in final printed copy.

Form Attaches To:

Owners Workers Compensation and Employers Liability Insurance Policy

Use: Policy jacket

Status of Filing in Domicile: Not Filed

Domicile Status Comments:

Reference Number:

Advisory Org. Circular:

Deemer Date:

<i>SERFF Tracking Number:</i>	<i>AOIC-125823827</i>	<i>State:</i>	<i>Arkansas</i>
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Revisions to the form include:

We are removing the "Dynamic Data" (Officers Signatures) from the filed form only. This will eliminate the necessity to refile the form each time we change officers. The content text has not changed.

If you have any questions please feel free to contact my associate Marcy Savage at savage.marcy@aoins.com or me as indicated below.

Thank you.

GARY M. MANDLEY, CPCU, MANAGER

WORKERS COMPENSATION & UNDERWRITING FIELD SERVICES

MANDLEY.GARY@AOINS.COM (emails without attachments)

commmlinesund@aoins.net (emails with attachments)

517-323-8794

Company and Contact

Filing Contact Information

Gary Mandley, Manager

PO Box 30660

Lansing, MI 48909-8160

mandley.gary@aoins.com

(800) 346-0346 [Phone]

(517) 391-1903[FAX]

Filing Company Information

Owners Insurance Company

P.O. Box 30660

Lansing, MI 48909-8160

CoCode: 32700

Group Code: 280

Group Name: Auto-Owners Ins
Group

FEIN Number: 34-1172650

State of Domicile: Ohio

Company Type: PC

State ID Number:

(800) 346-0346 ext. [Phone]

Filing Fees

Fee Required? No

Retaliatory? No

Fee Explanation:

Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Owners Insurance Company	\$0.00	09/19/2008	
Owners Insurance Company	\$50.00	09/19/2008	22613291

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Carol Stiffler	09/19/2008	09/19/2008
Objection Letters and Response Letters			

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending	Carol Stiffler	09/19/2008	09/19/2008	Jessica Turner	09/19/2008	09/19/2008
Industry Response						

SERFF Tracking Number: *AOIC-125823827*

State: *Arkansas*

Filing Company: *Owners Insurance Company*

State Tracking Number: *EFT \$50*

Company Tracking Number: *WCP-AR-04-09/19/2008-27016*

TOI: *16.0 Workers Compensation*

Sub-TOI: *16.0004 Standard WC*

Product Name: *Workers Compensation*

Project Name/Number: *WCP/27016 WCP*

Disposition

Disposition Date: 09/19/2008

Effective Date (New): 09/19/2008

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	AOIC-125823827	State:	Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Form	Owners Workers Compensation and Employers Liability Insurance Policy Jacket	Approved	Yes

SERFF Tracking Number: AOIC-125823827 *State:* Arkansas
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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 09/19/2008
Submitted Date 09/19/2008

Respond By Date

Dear Gary Mandley,

This will acknowledge receipt of the captioned filing.

All form filings have a filing fee of \$50. There is nothing in the filing to indicate that you are sending a check or an EFT. I can approve the filing contingent on receiving the filing fee if you will confirm that the filing fee is being sent.

Please feel free to contact me if you have questions.

Sincerely,

Carol Stiffler

Response Letter

Response Letter Status Submitted to State
Response Letter Date 09/19/2008
Submitted Date 09/19/2008

Dear Carol Stiffler,

Comments:

Response 1

Comments: Dear Carol Stiffler,

I apologize for the oversight. I have submitted the EFT payment.

Thank you,

Jessica Turner

Changed Items:

No Supporting Documents changed.

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No Form Schedule items changed.

No Rate/Rule Schedule items changed.

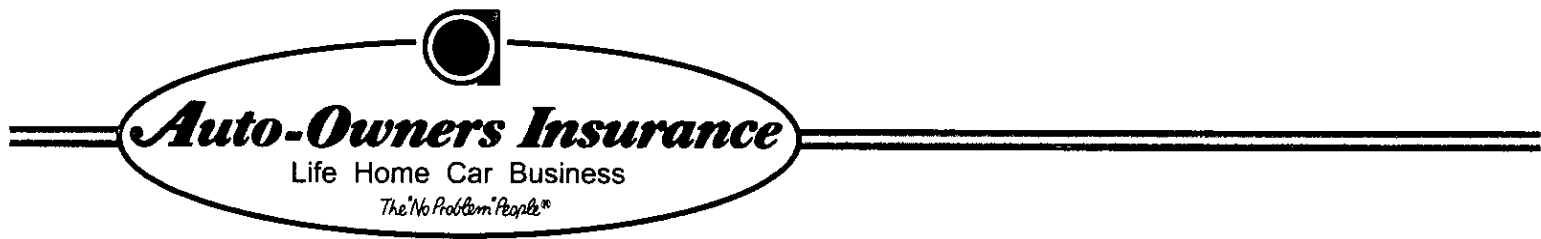
Sincerely,

Claudia Stewart, Jessica Turner, Sarah Franklin

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Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Owners Workers Compensation and Employers Liability Insurance Policy Jacket	27016	07-08	Policy/Coverage Replaced Form	Replaced Form #:0.00 27016 04-92 Previous Filing #:		27016 07-08.pdf



Workers Compensation and Employers Liability Insurance Policy

Owners Insurance Company

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY QUICK REFERENCE

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IMPORTANT: This Quick Reference is **not** part of the Workers Compensation and Employers Liability Insurance Policy, and does **not** provide coverage. Refer to the Workers Compensation and Employers Liability Insurance Policy itself for actual contractual provisions.

PLEASE READ THE WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY CAREFULLY

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

In return for the payment of the premium and subject to all terms of this policy, we agree with you as follows:

GENERAL SECTION

A. The Policy

This policy includes at its effective date the Information Page and all endorsements and schedules listed there. It is a contract of insurance between you (the employer named in Item 1 of the Information Page) and us (the insurer named on the Information Page). The only agreements relating to this insurance are stated in this policy. The terms of this policy may not be changed or waived except by endorsement issued by us to be part of this policy.

B. Who Is Insured

You are insured if you are an employer named in Item 1 of the Information Page. If that employer is a partnership, and if you are one of its partners, you are insured, but only in your capacity as an employer of the partnership's employees.

C. Workers Compensation Law

Workers Compensation Law means the workers or

workmen's compensation law and occupational disease law of each state or territory named in Item 3.A. of the Information Page. It includes any amendments to that law which are in effect during the policy period. It does not include any federal workers or workmen's compensation law, any federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

D. State

State means any state of the United States of America, and the District of Columbia.

E. Locations

This policy covers all of your workplaces listed in Items 1 or 4 of the Information Page; and it covers all other workplaces in Item 3.A states unless you have other insurance or are self-insured for such workplaces.

PART ONE — WORKERS COMPENSATION INSURANCE

A. How This Insurance Applies

This workers compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. Bodily injury by accident must occur during the policy period.
2. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

B. We Will Pay

We will pay promptly when due the benefits required of you by the workers compensation law.

C. We Will Defend

We have the right and duty to defend at our expense any claim, processing or suit against you for benefits payable by this insurance. We have the right to investigate and settle these claims, proceedings or suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

D. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

E. Other Insurance

We will not pay more than our share of benefits and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

F. Payments You Must Make

You are responsible for any payments in excess of the benefits regularly provided by the workers compensation law including those required because:

1. of your serious and willful misconduct;
2. you knowingly employ an employee in violation of law;
3. you fail to comply with a health or safety law or regulation; or
4. you discharge, coerce or otherwise discriminate against any employee in violation of the workers compensation law.

If we make any payments in excess of the benefits regularly provided by the workers compensation law on your behalf, you will reimburse us promptly.

G. Recovery From Others

We have your rights, and the rights of persons entitled to the benefits of this insurance, to recover our payments from anyone liable for the injury. You will do everything necessary to protect those rights for us and to help us enforce them.

H. Statutory Provisions

These statements apply where they are required by law.

1. As between an injured worker and us, we have notice of the injury when you have notice.
2. Your default or the bankruptcy or insolvency of you or your estate will not relieve us of our duties under this insurance after an injury occurs.
3. We are directly and primarily liable to any person entitled to the benefits payable by this insurance. Those persons may enforce our duties; so may an agency authorized by law. Enforcement may be against us or against you and us.
4. Jurisdiction over you is jurisdiction over us for purposes of the workers compensation law. We are bound by decisions against you under that law, subject to the provisions of this policy that are not in conflict with that law.
5. This insurance conforms to the parts of the workers compensation law that apply to:
 - a. benefits payable by this insurance; or
 - b. special taxes, payments into security or other special funds, and assessments payable by us under that law.
6. Terms of this insurance that conflict with the workers compensation law are changed by this statement to conform to that law.

Nothing in these paragraphs relieves you of your duties under this policy.

PART TWO — EMPLOYERS LIABILITY INSURANCE

A. How This Insurance Applies

This employers liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.
2. The employment must be necessary or incidental to your work in a state or territory listed in Item 3.A. of the Information Page.
3. Bodily injury by accident must occur during the policy period.
4. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the

conditions causing or aggravating such bodily injury by disease must occur during the policy period.

5. If you are sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

B. We Will Pay

We will pay sums you legally must pay as damages because of bodily injury to your employees, provided the bodily injury is covered by this Employers Liability Insurance.

The damages we will pay, where recovery is permitted by law, include damages:

1. for which you are liable to a third party by reason of claim or suit against you by that third party to recover the damages claimed against such third party as a result of injury to your employee;
2. for care and loss of services; and
3. for consequential bodily injury to a spouse, child, parent, brother or sister of the injured employee;

provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you; and

4. because of bodily injury to your employee that arises out of and in the course of employment, claimed against you in a capacity other than as employer.

C. Exclusions

This insurance does not cover:

1. liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers.
4. any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. bodily injury intentionally caused or aggravated by you;
6. bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
7. damages arising out of coercion criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;
8. bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901-950), the Nonappropriated Fund Instrumentalities Act (5 USC

Sections 8171 - 8173), the Outer Continental Shelf Lands Act (43 USC Sections 1331 -1356), the Defense Base Act (42 USC Sections 1651 - 1654), the Federal Coal Mine Health and Safety Act of 1969 (30 USC Sections 901-942), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;

9. bodily injury to any person in work subject to the Federal Employers' Liability Act (45 USC Sections 51-60), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;
10. bodily injury to a master or member of the crew of any vessel;
11. fines or penalties imposed for violation of federal or state law; and
12. damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 USC Sections 1801 - 1872) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. We Will Defend

We have the right and duty to defend, at our expense, any claim, proceeding or suit against you for damages payable by this insurance. We have the right to investigate and settle these claims, proceedings and suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance. We have no duty to defend or continue defending after we have paid our applicable limit of liability under this insurance.

E. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding, or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

F. Other Insurance

We will not pay more than our share of damages and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance and self-insurance will be equal until the loss is paid.

G. Limits of Liability

Our liability to pay for damages is limited. Our limits of liability are shown in Item 3.B. of the Information Page. They apply as explained below.

1. **Bodily Injury by Accident.** The limit shown for "bodily injury by accident - each accident" is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident.

A disease is not bodily injury by accident unless it results directly from bodily injury by accident.

2. **Bodily Injury by Disease.** The limit shown for "bodily injury by disease - policy limit" is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of employees who sustain bodily injury by disease. The limit shown for "bodily injury by disease - each employee" is the most we will pay for all damages because of

bodily injury by disease to any one employee.

Bodily injury by disease does not include disease that results directly from a bodily injury by accident

3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

H. Recovery From Others

We have your rights to recover our payment from anyone liable for an injury covered by this insurance. You will do everything necessary to protect those rights for us and to help us enforce them.

I. Actions Against Us

There will be no right of action against us under this insurance unless:

1. You have complied with all the terms of this policy; and
2. The amount you owe has been determined with our consent or by actual trial and final judgment.

This insurance does not give anyone the right to add us as a defendant in an action against you to determine your liability. The bankruptcy or insolvency of you or your estate will not relieve us of our obligations under this Part.

PART THREE — OTHER STATES INSURANCE

A. How This Insurance Applies

1. This other states insurance applies only if one or more states are shown in Item 3.C. of the Information Page.
2. If you begin work in any one of those states after the effective date of this policy and are not insured or are not self-insured for such work, all provisions of the policy will apply as though that state were listed in Item 3.A of the Information Page.
3. We will reimburse you for the benefits required by the workers compensation law of that state

if we are not permitted to pay the benefits directly to persons entitled to them.

4. If you have work on the effective date of this policy in any state not listed in Item 3.A of the Information Page, coverage will not be afforded for that state unless we are notified within thirty days.

B. Notice

Tell us at once if you begin work in any state listed in Items 3.C of the Information Page.

PART FOUR — YOUR DUTIES IF INJURY OCCURS

Tell us at once if injury occurs that may be covered by this policy. Your other duties are listed here.

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses

of the injured persons and of witnesses, and other information we may need.

3. Promptly give us all notices, demands and legal papers related to the injury, claim, proceeding or suit.

4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE — PREMIUM

A. Our Manuals

All premiums for this policy will be determined by our manuals of rules, rates, rating plans and classifications. We may change our manuals and apply the changes to this policy if authorized by law or a governmental agency regulating this insurance.

B. Classifications

Item 4 of the Information Page shows the rate and premium basis for certain business or work classifications. These classifications were assigned based on an estimate of the exposures you would have during the policy period. If your actual exposures are not properly described by those classifications, we will assign proper classifications, rates and premium basis by endorsement to this policy.

C. Remuneration

Premium for each work classification is determined by multiplying a rate times a premium basis. Remuneration is the most common premium basis. This premium basis includes payroll and all other remuneration paid or payable during the policy period for the services of:

1. all your officers and employees engaged in work covered by this policy; and
2. all other persons engaged in work that could make us liable under Part One (Workers Compensation Insurance) of this policy. If you do not have payroll records for these persons, the contract price for their services and materials may be used as the premium basis. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured their workers compensation obligations.

D. Premium Payments

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid.

E. Final Premium

The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium will be determined after this policy ends by using the actual, not the estimated, premium basis and the proper classifications and rates that lawfully apply to the business and work covered by this policy. If the final premium is more than the premium you paid to us, you must pay us the balance. If it is less, we will refund the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.

If this policy is canceled, final premium will be determined in the following way unless our manuals provide otherwise.

1. If we cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.
2. If you cancel, final premium will be more than pro rata; it will be based on the time this policy was in force, and increased by our short-rate cancellation table and procedure. Final premium will not be less than the minimum premium.

F. Records

You will keep records of information needed to compute premium. You will provide us with copies of those records when we ask for them.

G. Audit

You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

PART SIX — CONDITIONS

A. Inspection

We have the right, but are not obligated to inspect your workplaces at any time. Our inspections are not safety inspections. They relate only to the insurability of the workplaces and the premiums to be charged. We may give you reports on the conditions we find. We may also recommend changes. While they may help reduce losses, we do not undertake to perform the duty of any person to provide for the health or safety of your employees or the public. We do not warrant that your workplaces are safe or healthful or that they comply with laws, regulations, codes or standards. Insurance rate service organizations have the same rights we have under this provision.

B. Long Term Policy

If the policy period is longer than one year and sixteen days, all provisions of this policy will apply as though a new policy were issued on each annual anniversary that this policy is in force.

C. Transfer of Your Rights and Duties

Your rights or duties under this policy may not be transferred without our written consent.

If you die and we receive notice within thirty days after your death, we will cover your legal representative as insured.

D. Cancellation

1. If you cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel this policy. We must mail or deliver to you not less than ten days advance written notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
3. The policy period will end of the day and hour stated in the cancellation notice.
4. Any of these provisions that conflict with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

E. Sole Representative

The insured first named in Item 1 of the Information Page will act on behalf of all insureds to change this policy, receive return premium, and give or receive notice of cancellation.

In witness whereof, we, the Owners Insurance Company, have caused this policy to be issued and to be duly signed by our President and Secretary.

<i>SERFF Tracking Number:</i>	<i>AOIC-125823827</i>	<i>State:</i>	<i>Arkansas</i>
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Rate Information

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>AOIC-125823827</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Owners Insurance Company</i>	<i>State Tracking Number:</i>	<i>EFT \$50</i>
<i>Company Tracking Number:</i>	<i>WCP-AR-04-09/19/2008-27016</i>		
<i>TOI:</i>	<i>16.0 Workers Compensation</i>	<i>Sub-TOI:</i>	<i>16.0004 Standard WC</i>
<i>Product Name:</i>	<i>Workers Compensation</i>		
<i>Project Name/Number:</i>	<i>WCP/27016 WCP</i>		

Supporting Document Schedules

Satisfied -Name:	Uniform Transmittal Document-Property & Casualty	Review Status:	Approved	09/19/2008
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Comments:

Attachment:

27016 Transmittal.pdf

Property & Casualty Transmittal Document

Reset Form

**1. Reserved for Insurance
Dept. Use Only****2. Insurance Department Use only**

a. Date the filing is received:

b. Analyst:

c. Disposition:

d. Date of disposition of the filing:

e. Effective date of filing:

New Business

Renewal Business

f. State Filing #:

g. SERFF Filing #:

h. Subject Codes

3. Group Name	AUTO-OWNERS INSURANCE GROUP COMPANY				Group NAIC #
					280
4. Company Name(s)	Domicile	NAIC #	FEIN #	State #	
OWNERS INSURANCE COMPANY	Ohio	280-32700	34-1172650		

5. Company Tracking Number	WCP-AR-04-09/19/2008-27016
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Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6. Name and address	Title	Telephone #s	FAX #	e-mail
Gary M. Mandley, CPCU P.O. Box 30660 Lansing, MI 48909-8160	Manager	517-323-8794	517 391-1903	MANDLEY.GARY@AOINS.COM
7. Signature of authorized filer				
8. Please print name of authorized filer		Gary M. Mandley, CPCU, Manager		

Filing information (see General Instructions for descriptions of these fields)

9. Type of Insurance (TOI)	16.0 Workers Compensation
10. Sub-Type of Insurance (Sub-TOI)	16.0004 Standard WC
11. State Specific Product code(s)(if applicable)[See State Specific Requirements]	
12. Company Program Title (Marketing title)	Workers Compensation
13. Filing Type	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input checked="" type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14. Effective Date(s) Requested	New: On Approval Renewal:
15. Reference Filing?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
16. Reference Organization (if applicable)	
17. Reference Organization # & Title	
18. Company's Date of Filing	September 19, 2008
19. Status of filing in domicile	<input checked="" type="checkbox"/> Not Filed <input type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

Property & Casualty Transmittal Document—

20. This filing transmittal is part of Company Tracking #	WCP-AR-04-09/19/2008-27016
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21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]
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FORM FILING: 27016 (07-08) - Owners Workers Compensation and Employers Liability Insurance Policy
Submitted for your approval is the above-referenced form. Forms are submitted in final printed copy.
Form Attaches To:
Owners Workers Compensation and Employers Liability Insurance Policy
Use: Policy jacket
Revisions to the form include:
We are removing the "Dynamic Data" (Officers Signatures) from the filed form only. This will eliminate the necessity to refile the form each time we change officers. The content text has not changed.
If you have any questions please feel free to contact my associate Marcy Savage at savage.marcy@aoins.com or me as indicated below.
Thank you.
GARY M. MANDLEY, CPCU, MANAGER
WORKERS COMPENSATION & UNDERWRITING FIELD SERVICES
MANDLEY.GARY@AOINS.COM (emails without attachments)
commmlinesund@aoins.net (emails with attachments)
517-323-8794

[View Complete Filing Description](#)

22. Filing Fees (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #:
Amount:

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)

(Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	WCP-AR-04-09/19/2008-27016
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2.	This filing corresponds to rate/rule filing number (Company tracking number of rate/rule filing, if applicable)	
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3.	Form Name /Description/Synopsis	Form # Include edition date	Replacement Or withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state
01	Owners Workers Compensation and Employers Liability Insurance Policy Jacket	27016 07-08	<input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	27016 04-92	
02			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
03			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
04			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
05			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
06			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
07			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
08			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
09			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
10			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		

PC FFS-1

RATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	WCP-AR-04-09/19/2008-27016
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2.	This filing corresponds to form filing number (Company tracking number of form filing, if applicable)	
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☐ Rate Increase ☐ Rate Decrease ☐ Rate Neutral (0%)

3.	Filing Method (Prior Approval, File & Use, Flex Band, etc.)	
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4a.	Rate Change by Company (As Proposed)
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Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)

4b.	Rate Change by Company (As Accepted) For State Use Only
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Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5.	Overall Rate Information (Complete for Multiple Company Filings only)
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		COMPANY USE	STATE USE
5a	Overall percentage rate indication (when applicable)		
5b	Overall percentage rate impact for this filing		
5c	Effect of Rate Filing – Written premium change for this program		
5d	Effect of Rate Filing – Number of policyholders affected		

6.	Overall percentage of last rate revision	
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7.	Effective Date of last rate revision	
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8.	Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)	
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9.	Rule # or Page # Submitted for Review	Replacement or withdrawn?	Previous state filing number, if required by state
01		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	
02		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	
03		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	